SEPTEMBER 1959

# Bulletin

NATIONAL TUBERCULOSIS ASSOCIATION

FIGHT TB WITH CHRISTMAS SEALS
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NATIONAL
TUBERCULOSIS
ASSOCIATION

**Bulletin**

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EDITORIAL

# The Unique Values of the Christmas Seal Campaign

After 52 years as a tried and proven method of raising funds to combat tuberculosis, the Christmas Seal Campaign still stands today as one of the finest examples of independent fund raising in our country. And with a potential coverage of every home in the nation, the Christmas Seal Campaign also represents one of our most potent forces for health education.

This annual appeal offers each tuberculosis association an opportunity to interpret to every citizen the true current picture of the tuberculosis problem and the local activities still needed to bring the disease under control. And now that we face the necessity of extending our program into the area of other respiratory diseases in order to complete the job of controlling tuberculosis, the Christmas Seal Campaign gives us a further opportunity to enlighten people everywhere on the need for financial support for these expanded activities.

Although most tuberculosis associations conduct year-round information programs, it is still probably true that newspapers and other public information media expect to—and do—give more space to associations' activities at Christmas Seal time. More human interest and other stories, more reports of accomplishments, appear throughout the country during the months of the campaign than at any other time in the year.

This concentration of publicity in itself serves a direct educational purpose. In addition, the interest created by this increased emphasis on the problems of tuberculosis opens the door for further education, through requests for talks, pamphlets, movies, and consultation on how to solve other related problems created by TB.

Volunteers are another excellent source for furthering our educational program. We depend upon volunteers to do much of the mechanical work involved in the Christmas Seal Campaign. But we should also be aware that volunteers can do much to mold public opinion. They can become wonderful public relations people for us. Recognition of the great impact for good that volunteers can have on the community should not be overlooked.

Today, when considerable pressure is being exerted in many parts of the country for "one drive to end all drives," we should reaffirm our conviction that the Christmas Seal Campaign is one of the finest examples of the American democratic process in the field of fund raising in existence. But this campaign will only remain strong so long as we have continued faith in its rightness, in its still untapped fund-raising possibilities, and in the opportunities it gives us to educate the people to help support our future programs.

Remember, as Christmas Seals go into millions of homes throughout the land in the forthcoming months, that this is democracy in action, an investment in hope and faith that our homes and our lives will one day be free from tuberculosis. — **Thomas P. Summers,** *Chairman, Committee on Fund Raising Campaign, National Conference of Tuberculosis Workers*

# Why I believe in

# INDEPENDENT FUND RAISING

**By Ernest L. Stebbins, M.D.**

THE voluntary health agency movement is unique in the United States. True, there are voluntary health agencies in other countries, but in no country have they developed to the extent that they have in the United States.

In seeking the reasons for this development, I am inclined to believe that it is an expression of the unusual degree of independence that characterizes the citizens of this nation. It seems to be related to the pioneering spirit of our forebears. In the pioneer community, life was frequently fraught with danger and hardship, and a strong feeling grew up that the unfortunate should be assisted by the fortunate, not as a matter of legal responsibility or government social security, but as a voluntary philanthropic activity. This reaction was reflected in the early development of philanthropic organizations as the communities in this country became more complex. Rather than neighbor helping neighbor, organized groups were formed to help others.

The voluntary hospital movement in this country is a good example of the desire on the part of the people to provide, on a voluntary basis, assistance for the sick and the needy. The settlement house developments in our large cities were another evidence of a voluntary response to a need recognized within the community.

These developments also emphasized the importance of certain disease problems. The association of poverty with disease was clearly recognized, and the prevention of disease as a means of preventing poverty appealed strongly to public-spirited individuals. We see in the development of a number of our present voluntary health organizations the influence of – even if they are not actually an outgrowth of–charitable or philanthropic organizations.

There was also a practical aspect to the development of many of the voluntary agencies. The magnitude of the problem of caring for the sick was so overwhelming that those interested in disease problems turned quite naturally to prevention as a reasonable goal in view of the limited resources available.

The National Tuberculosis Association, as the first of the great voluntary health agencies, evolved a pattern of activity which has been followed more or less in detail by the rapidly increasing numbers of such agencies during the past half

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**The 1960 Annual Meetings of the National Tuberculosis Association, the American Trudeau Society, and the National Conference of Tuberculosis Workers will be held in Los Angeles, Calif., May 15-20. Full information about hotel accommodations will appear in the November *Bulletin*.**

**Will anyone who has ideas or materials for exhibits, movies, or TV programs please write to Elliott A. Rouff, M.D., chairman, 1960 Exhibits Subcommittee, 1930 Wilshire Blvd., Los Angeles 57, Calif.**

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century. This pattern is based on education, demonstration, research, professional education, and direct service. The success of the NTA and the other voluntary agencies in carrying out these activities has been one of the notable health achievements of this century.

As one interested in the continued improvement of the health of the people of this country, I view with alarm what appears to be an increasing force in opposition to the independent drive for funds on the part of the voluntary health agencies. One hears more and more frequently criticism of the increasing numbers of these agencies. It is true that there has been an increase, and this I consider to be good. It has been amply demonstrated that a group of citizens joining together to combat a specific disease attract to themselves those with similar interests and concerns, either as a result of personal experience or merely because they have learned of the importance of this special disease problem. This is a sociologic characteristic of the people of this country that seems to be inherent in our very being. We like to organize, and we are good organizers. We get "steamed up" about problems. I don't think that anything that anyone can do will stop this natural tendency, whether it be in the health field or in any other.

We in the United States pride ourselves on our concept of democracy, the freedom and the dignity of the individual. We believe in free enterprise and freedom of decision. It seems to me that this should include the freedom to make our own decisions as to whom we shall give and how we shall give, both of our money and of our time, in voluntary efforts such as represented by the voluntary health agencies.

It is argued that the multitude of appeals antagonize the giver and might eventually result in his not giving. The facts certainly do not bear out this point of view. Public giving to the voluntary health agencies during the past ten to fifteen years has increased phenomenally, and this during a period when there was undoubtedly the greatest increase in appeals in the history of our country.

I wonder if the advocates of federated fund raising would be as concerned about eliminating duplication of effort and the avoidance of multiple appeals in other fields. Take, just as an example, the insurance field. I believe that there are more insurance companies than there are voluntary health agencies. There would seem to be at least an equal possibility of standardization in this field. In fact, these companies are to a certain extent standardized by law. I think we can be reasonably sure that insurance in one company is about as reliable as that in another. I think we can be reasonably sure also that there is no marked difference in premiums charged for the same policy. Yet I have more insurance agents call upon me in a given year than I have representatives of voluntary health agencies. I certainly get a great deal more mail from insurance companies than I do from voluntary health agencies. I am annoyed by this, but it hasn't kept me from being insured. I have no intention of starting a campaign to consolidate all insurance companies. If I did, however, and if I were successful, I have a feeling that our government would frown upon such a move.

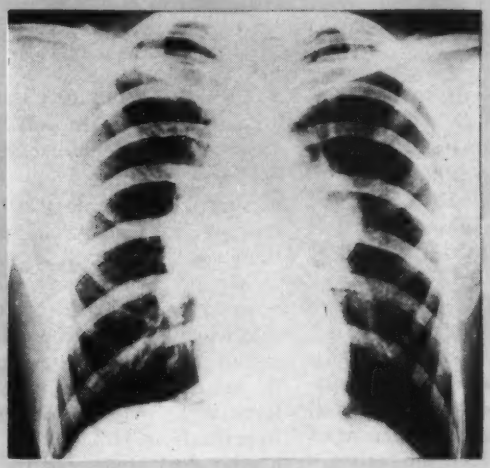
I believe firmly that the success of the movement for completely federated fund raising would result in a gradual decrease in funds available for these health activities, but more important would result in a crippling of the educational aspects of the health agencies, and in so doing, impede progress in the health field, not only on the part of the voluntary health agencies, but in the official health agencies of our country.

## New NTA Division

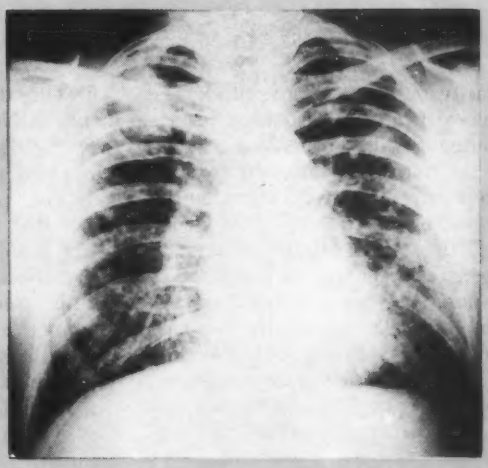
**A new single Division of Research and Statistics of the National Tuberculosis Association was established effective July 1, combining the former Medical Research Division and the Social Research Division. Floyd M. Feldmann, M.D., has been named director of the new division, and Donald A. Trauger, associate director.**

**This change results from action taken by the NTA Board of Directors on May 29, in Chicago. At that time the Board also resolved to discontinue the NTA Committee on Social Research and to combine its functions with those of the Committee on Medical Research. The new committee, to be known as the Committee on Research, will include persons trained in the social sciences. In future, all promotion and evaluation of research grants, whether social or medical, will be handled by the new committee.**

**Dr. Stebbins is director of the School of Hygiene and Public Health, Johns Hopkins University, Baltimore, and professor of public health administration. From 1942 to 1946, he served as commissioner of health for New York City and was concurrently professor of epidemiology at Columbia University. Dr. Stebbins had formerly served with the New York State Health Department successively as epidemiologist, district health officer, director of the Division of Communicable Diseases, and assistant commissioner of health. He received his medical degree from Rush Medical School, University of Chicago. Dr. Stebbins' article was solicited by the Governing Council of the National Conference of Tuberculosis Workers and is adapted from his talk at NTA's annual meeting.**



Chest film of a patient with sarcoidosis, demonstrating the marked enlargement of the hilar lymph nodes—the so-called potato nodes.



Widespread infiltration and fibrosis on a chest film of a patient with sarcoidosis. He had been relatively asymptomatic for a year.

# The RIDDLE of SARCOIDOSIS

**By Max Michael, Jr., M.D.**

In 1869, Jonathan Hutchinson, a surgeon, noted a hitherto undescribed skin lesion. In his published report of 1898, he called it Mortimer's Malady, after the patient so afflicted. In 1897, Caesar Boeck described the same type of skin lesion as Mortimer's Malady and studied it pathologically. He called the lesion benign sarkoids. Since then, the disease has been frequently known as Boeck's sarcoid.

Over the years the disease's protean nature and widespread organ involvement have become recognized. Any number of seemingly unrelated syndromes are now known to be one and the same—sarcoidosis. The preferred terminology, sarcoidosis, indicates its widespread involvement of the body, as indeed any organ or tissue may be affected, especially the lungs, eyes, skin, bones, spleen, and lymph nodes.

In the lungs, these lesions may be widespread and miliary in nature, simulating miliary tuberculosis in many respects. The lymph nodes in the chest may be quite enlarged. Involvement of the eyes can be serious, leading in some instances to blindness. The symptomatology is exceedingly variable. Many patients' sarcoidosis is detected on a routine chest film, and may run the gamut of a variety of pulmonary lesions, without any symptoms of note. Other patients experience mild shortness of breath and interference with respiratory function. In yet another group, the onset is acute, with diffuse pulmonary infiltration, fever, and overwhelming dyspnea.

The disease may heal completely without residua, or may progress to diffuse fibrosis and scarring in the lungs, leaving the patient a pulmonary cripple. The bone lesions, which occur in a small percentage of individuals, are punched-out, circumscribed areas in the tips of the fingers and toes. These are usually asymptomatic and are recorded only on radiography. Rarely is arthritis noted. Less commonly, invasion of the cardiac muscle can result in heart failure and in a variety of abnormal rhythms. The central nervous system manifestations, with nerve paralysis, convulsions, etc., are infrequent but quite alarming.

Certain interesting laboratory findings are recorded. The plasma proteins, particularly the gamma globulins, are often elevated, as is the serum calcium. Patients with sarcoidosis display a unique type of skin sensitivity, in that they have a high incidence of negative tuberculin reactions. This held true several decades ago, when positive tuberculin reactors were much more frequent in the population at large than they are today. Similar poor skin reactivity to a number of other antigens, such as mumps and various fungi, has been demonstrated.

The most challenging and certainly the most controversial aspect of sarcoidosis has been its etiology. Early investigators were impressed by certain similarities between the pathologic features of sarcoidosis and tuberculosis. In some series of cases, a fairly high percentage of patients with sarcoidosis later were noted to develop tuberculosis. On the other hand, some investigators believed this relationship to be negligible. These divergent reports have not been satisfactorily explained. The above-mentioned high incidence of negative tuberculin reactors has suggested to some investigators a peculiar type of allergy to the tubercle bacillus, whereby the patients respond with the sarcoid picture to the tubercle bacillus. Much effort has been expended to prove or disprove this etiologic relationship. The tubercle bacillus has not been, with any

regularity, isolated from either the sputum or from the pathologic lesions of patients with sarcoidosis. Moreover, the antituberculous drugs, such as streptomycin, have no effect on the course of the disease.

It is this writer's belief that in a very small percentage of the cases of sarcoidosis the tubercle bacillus may be the etiologic agent. In the vast majority of cases this is not the offending pathogen. It has been suggested that a variety of fungi or viruses can cause the disease; however, no positive proof has been forthcoming.

A somewhat different approach to the disease's etiology was the study of its epidemiology. The disease is worldwide in distribution, but has been particularly prevalent in the Scandinavian countries, England, Germany, and the United States. Both sexes are affected with about equal frequency. Sarcoidosis has been detected in all age groups, but the peak incidence is among 20- to 40-year-olds. A study of World War II military personnel whose disease was first diagnosed during their military service indicated that some previously suggested premises were indeed correct. The large number of cases made it possible to draw statistically correct conclusions.

1. In the United States, the disease is most prevalent in those born in the southeastern United States. A study of veterans in whom the disease was diagnosed since World War II has confirmed this and has extended the "endemic" area to include small portions of the Midwest and the New England States. It is interesting how infrequently the disease is noted in inhabitants of the western half of this country.

2. The highest incidence has occurred in those with a predominantly rural residence. This has also been noted in the Scandinavian countries.

3. The disease occurs more commonly in Negroes than in whites, the ratio being approximately 17 to 1 when corrected for population.

4. The epidemiology thus indicated is not that of tuberculosis, the latter being more urban than rural in its distribution.

The geographic distribution prompted a study of certain ecologic factors. A statistically significant distribution of birthplaces of these patients fell below the geographic fall line. This area has fairly specific types of superficial soil, which interestingly enough have their source in parent rocks which are high in beryllium. This proved a tempting lead because of the many clinical and pathologic features shared in common by sarcoidosis and the disease resulting from exposure to beryllium fumes in certain individuals. Indeed, when beryllium disease was first recognized, it was known as Salem Sarcoid. Study of the soil, however, in the "endemic sarcoid" area did not reveal a significant concentration of beryllium, nor has it been isolated from the tissue of patients with sarcoidosis.

Another feature that attracted interest early in the epidemiologic studies was the possible association with certain types of forests. It was noted that many of the individuals had been actively engaged in the pine industry, either in lumber, naval stores, or the like. Furthermore, the distribution of birthplace of these patients coincided quite nicely with the distribution of the eastern pine forests. Cummings and his coworkers have pursued the pine tree-sarcoidosis relationship in great detail. They have demonstrated certain chemical similarities between pine pollen, fractions of the tubercle bacillus, and certain components of the sarcoid lesion. Moreover, using fractions of the pine pollen, they have been able to produce lesions somewhat resembling the sarcoid tubercle in experimental animals.

Thus it is attractive at the moment to speculate whether this bizarre disease, with its many clinical and epidemiologic peculiarities, represents a rather unusual tissue reaction, perhaps "allergic" in nature, to the prosaic weedlike pine tree, which within recent decades has come into its own in industry. Studies continue on a large scale, to prove or disprove this hypothesis, in Jacksonville, Florida, in a laboratory sponsored by the Veterans Administration in conjunction with the Jacksonville Hospitals Educational Program. Skin testing of patients with sarcoidosis and of appropriate controls with various pine antigens, in both endemic and nonendemic areas, mass chest film surveys, animal investigation, and further epidemiologic studies are in progress.

The question still remains whether the disease we recognize as sarcoidosis is indeed a "pure culture" disease, caused by one agent, or whether it is a syndrome, caused by multiple agents. As mentioned earlier, the complete disease picture can be produced by beryllium. Similarly rare instances have been recorded of the picture being caused by the fungus *Histoplasma capsulatum*. It is quite probable that a very small number of cases are caused by the tubercle bacillus. Many seemingly unrelated factors can evoke the pathologic picture of the isolated sarcoid tubercle. Thus it is possible that a variety of agents can evoke the clinical picture which we recognize as sarcoidosis. Perhaps pine pollen is the most common etiologic agent in this part of the world. Further study is needed to clarify these points.

The treatment of sarcoidosis is symptomatic in most patients. Cortisone and related adrenal steroids will produce a lessening of the disease process. Temporary improvement results in most patients, but when the drugs are discontinued, the disease frequently returns to its former level. It is generally felt that these drugs should be used only as lifesaving measures, or where there is considerable incapacity from involvement of the lungs, or threatened loss of vision.

Dr. Michael is executive director of the Jacksonville Hospitals Educational Program and professor of clinical medicine at the University of Florida. From 1954 to 1958, he was professor of medicine at State University of New York and director of Medical Services at Maimonides Hospital, Brooklyn. Prior to this, Dr. Michael served as chief of Medical Services at the Veterans Administration Hospital, Atlanta, Ga. He received his medical degree from Harvard University. Dr. Michael's article was solicited by the Committee on Medical Public Relations of the American Trudeau Society.

Press Project students interview Senator Frank Lausche.

# SCHOOL PRESS PROJECT

New York City winners are honored at special UN ceremony.

As sometimes happens with a sound program idea, the School Press Project got its start more by accident than design when, nearly a quarter of a century ago, a few school publications entered in the Columbia Scholastic Press Association's annual contest arrived with Christmas Seals pasted on them. The CSPA told the National Tuberculosis Association about these entries, and the School Press Project was born.

In 1937, the two organizations announced that they would jointly sponsor a contest to encourage school journalists to write news and feature stories and editorials on the Christmas Seal program. That first year, schools in ten states submitted entries, and nine winners were selected. Last year, in 1958, approximately 1,000 schools from 36 states and the District of Columbia entered the Project, and 120 Certificates of Honor were awarded.

Among the many imaginative devices to promote student interest and participation in the 1958 Project was that used in Montgomery County (Dayton, Ohio).

Until last year, the School Press Project in Montgomery County seemed to be getting into a rut—with dry, unimaginative entries that won few awards in state or national competition.

When the Mississippi Valley Conference on Tuberculosis was held in Dayton last October, the state and local tuberculosis associations saw a solution to the problem. The conference not only would be attended by some of the best-trained tuberculosis workers in the country, but Frank J. Lausche, United States Senator from Ohio, was to be keynote speaker. Letters were sent to the journalism instructors and to English teachers inviting their students to become honorary tuberculosis workers for the four days of the conference and to cover as many sessions as they wished.

The result: Some 70 students from 11 schools, including three that had never previously participated in the Project, attended.

The Montgomery County Tuberculosis and Health Association made a photographer available, so that student editors could set up any picture they wanted. The future newspaper reporters were then turned loose upon the conference, where they interviewed Senator Lausche and tuberculosis workers from all 12 of the states represented.

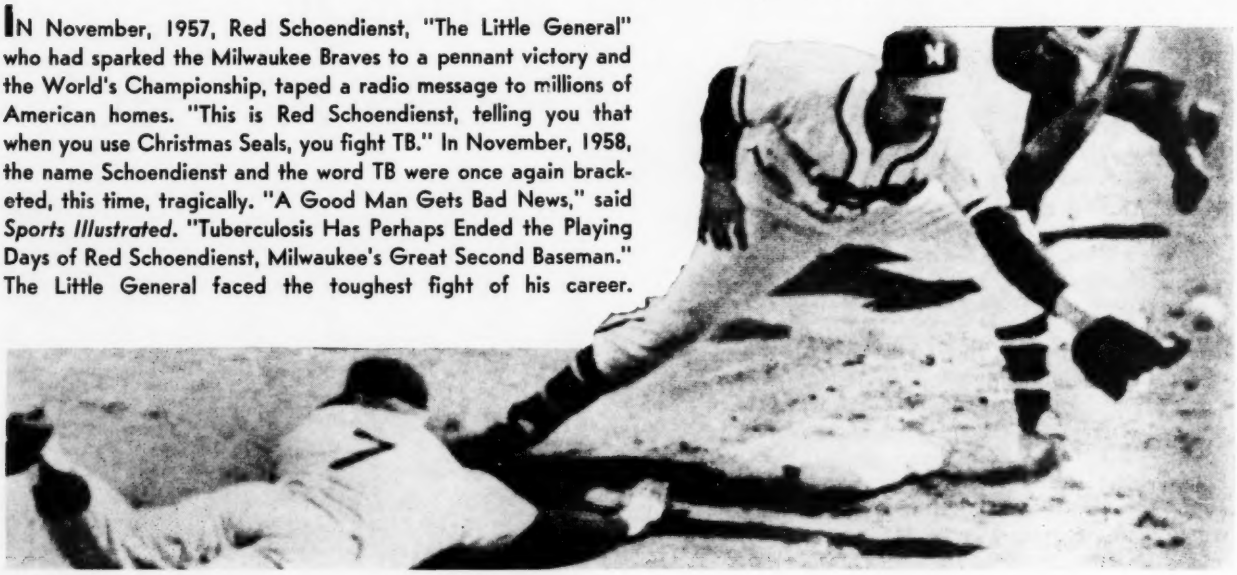
The students not only talked to Senator Lausche about his thoughts on tuberculosis, but got an exclusive on his stand on the controversial Right-to-Work Law, which was then before the Ohio voters. This made the headlines, with a picture of Lausche and the school children on the front page of Dayton's biggest newspaper, the *Dayton Daily News*. The story was also carried on the wire services.

A group of New York City associations found an unusual method of honoring its Press Project winners last year when the Queensboro Tuberculosis and Health Association, the Brooklyn Tuberculosis and Health Association, and the New York Tuberculosis Association arranged a special ceremony at the United Nations headquarters in New York City. Above, Dr. Rodolphe Coigney (left), liaison officer of the World Health Organization, presents Certificates of Honor to the student winners.

A showing of "Are You Positive?" to student journalists started off the School Press Project of the Patrick Henry Tuberculosis Association in Martinsville, Virginia. The film was followed by an open discussion to give the students local facts about tuberculosis. Later, a field trip to Catawba Sanatorium was arranged, at a time convenient for both the teacher and the hospital superintendent, with cars for transportation provided by the tuberculosis association. At the hospital, students were conducted through wards, the occupational therapy department, X-ray rooms, and classrooms, and were permitted to sit in on a weekly staff meeting. The following week, the tuberculosis association held a press conference to provide any additional information students might require.

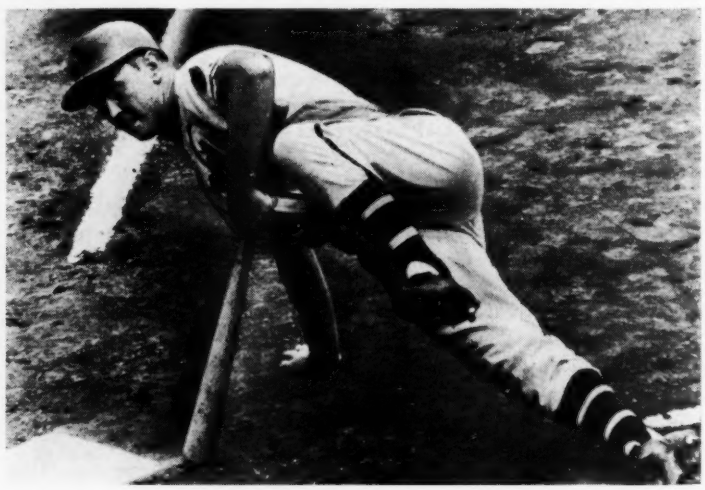
# "I never dreamed it could happen to me . . .

IN November, 1957, Red Schoendienst, "The Little General" who had sparked the Milwaukee Braves to a pennant victory and the World's Championship, taped a radio message to millions of American homes. "This is Red Schoendienst, telling you that when you use Christmas Seals, you fight TB." In November, 1958, the name Schoendienst and the word TB were once again bracketed, this time, tragically. "A Good Man Gets Bad News," said *Sports Illustrated*. "Tuberculosis Has Perhaps Ended the Playing Days of Red Schoendienst, Milwaukee's Great Second Baseman." The Little General faced the toughest fight of his career.



Red, shown above with loyal wife Mary and two of their three daughters, Colleen and Cathleen, shared much-deserved limelight with Braves on parade the night of clinching their second consecutive pennant. Schoendienst, hailed by sports writers as "The glue which stuck the Braves together," welcomed the breather prior to the opening of the Series. His side still hurt. He had a routine chest X-ray—as did the rest of the Braves. Results were negative. The seven-game Series proved a real ordeal, but Red's playing was inspired—and courageous. At right, he ducks a low pitch. One more injury would have been too much. He decided on a further check-up once back home again.

Red, a veteran of ten seasons with the St. Louis Cardinals, hit a resounding .300 in 1957 for the Braves, and made many a sparkling infield play for a team which was to upset the New York Yankees in the World Series. But 1958 was another year and a different story. Red was plagued with illness and injuries from spring training on. Rib injuries were followed by a heavy cold; the cold developed into pleurisy. Breathing was difficult, and his side caused him considerable pain, made every movement difficult. Sore shoulder muscles, then a broken finger, conspired to drag his batting average down to .262—the second lowest in his career—and complete what Red laconically described as a "rugged" season. But pain and fatigue failed to dampen his competitive spirit; Red's on-the-field performance was described as "outstanding." The Braves again won the National League flag.



Milwaukee lost the World Series—a blow to any baseball family—but matters of much deeper concern took over in the Schoendienst home in St. Louis. Red had an intensive physical examination, including another chest X-ray. Mary was expecting their fourth child. Both were awaiting the medical verdict on Red when Mary gave birth to Kevin. This memorable November was far from over; events to come followed swiftly one upon the other.

Kevin was born via Caesarian section (like his three sisters) on November 3, 1958. On the 8th came the report that Red's "pictures" didn't look good. He went into St. John's Hospital. Guinea pig tests were made. Four days later, November 12, he was transferred to Mount St. Rose Hospital. It was official. He was suffering from active tuberculosis. Mary and the youngsters were X-rayed. Results, negative. Within six weeks, Red, shown above with Sister Jean, received 10,000 pieces of mail. For the active, time to contemplate is measured in precious minutes. For the inactive, it is ever present in superabundance. Red had plenty of time in the hospital to reflect upon what seemed like the irony of an athlete, a 16-year veteran, breaking down with tuberculosis. "I never dreamed it could happen to me," he commented. "But I found out it can happen to anybody."

but I found out it can happen to anybody"

Daddy's back! Worst of the siege, said Red, was absence from his devoted wife; Colleen, seven; Cathleen, six; Eileen, two, and baby Kevin. Still ahead was more rest, continued treatment. By mid-May Red was able to attend a game, talk shop with catcher Del Rice (see right), and enjoy backyard "practice" with Cathy. Six weeks later Schoendienst was back in uniform, taking light workouts with the Braves. One thing was certain: November '59 would be a happy contrast to November '58. Red Schoendienst had racked up his biggest victory of all.

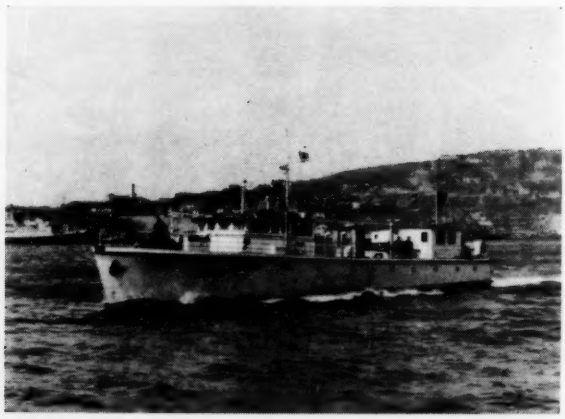
Prescription for recovery included regimen of rest and modern drugs and, in time, surgery. Red was operated on in mid-February. He responded favorably to hospital treatment—and to the vital therapy of constant "We know you'll make it, Red!" good wishes, a renewed contract for '59, and, most of all, anticipation of his eventual return to his home, his wife, and the children. The happy day came, on the 24th of March.

*Photograph above, center, St. Louis Post-Dispatch*
*All other photographs, Wide World*

Patients at Mountain Sanatorium, Hamilton, practice carving—an increasing source of income for Eskimos.

# TB CONTROL in CANADA

By Anne Grant



Because there are no overland roads in Newfoundland, case finding is done by ship—the M. V. *Christmas Seal.*

In Canada's towns and cities, and in the country around them, tuberculosis control programs differ little from those in similar areas in the United States. A clinic in Pittsburgh and one in Toronto are much alike. Sanatoriums, particularly large ones, have a strong family likeness to their opposite numbers south of the 49th parallel. Wards, X-ray machines, operating rooms, and laboratories are all the same. The superintendents of the 64 sanatoriums seem to have the same worries, too.

But some tens of thousands of Canada's 17.3 million people live thousands of miles from a metropolitan area, and the farther one goes from cities, the more the varied and uncompromising geography demands flexibility and originality from workers, in addition to the diligence and persistence that are called for anywhere.

### CTA and Affiliates

When the Canadian Tuberculosis Association was organized, in 1900, there were seven provinces, none of which had organized health depart-

ments or tuberculosis associations. Today there are ten provinces, each with flourishing health departments and tuberculosis associations. The official and voluntary agencies work together to the great satisfaction of both. Formation of the provincial associations has been an important project of the CTA, one to which the founders pledged the efforts of the association when they drew up the constitution. Within the framework of the provincial bodies are 175 local and county associations. Dawson, Mayo, and Whitehorse, in the Yukon, also have associations carrying on Christmas Seal Sales.

### Down to the Sea in Ships

The Newfoundland Tuberculosis Association is the only one in Canada that owns a ship—but it needs one as no other province does. There are no overland roads to the 1,800 ports dotted along its 6,000-mile coast. The only way into them is by sea or, in emergency, by air, so it is by sea that TB diagnostic and preventive services come. The M.V. *Christmas Seal* noses into every little cove, no matter how small the population. "We'll stop for one man," Captain Peter Troake, the skipper, has said. When there is no dock, the villagers come out in dories and climb aboard.

The *Christmas Seal* comes into port to music: sometimes the vigorous tenor of Captain Troake is heard over the public-address system, and sometimes an X-ray technician acts as disc jockey and puts on the record player some lilting tune that the islanders love. This is followed by an invitation to use the services offered and an explanation of the benefits to be derived.

Sometimes a nursing team has traveled ahead of the *Christmas Seal*, giving tuberculin tests. The tests are read and BCG vaccination recommended for the negatives. Most Newfoundland parents want their children vaccinated. The provincial department of health delivers fresh BCG to the ship by plane at points along the way.

Positives and adults are given chest X-rays. The plates are read as the ship travels up the coast; as it comes down, it stops where active cases have been found, to arrange for the patient to have sanatorium treatment, which is provided free of charge by the Newfoundland Government.

The economy of centuries is breaking down for the Eskimo, and many must find a new way to make a living. At Mountain Sanatorium, classes are held for both children and adults as soon as they are well enough to learn, so that they may have a better chance for self-support. Bottom: Three of the many children patients at the sanatorium get ready to be sent back to their homes in the North.

Meanwhile, a nurse and a rehabilitation officer from the Newfoundland Department of Health have gone ashore, the rehabilitation officer to work on a survey of the mentally and physically handicapped and the nurse to visit ex-patients and their families. Since no transportation facilities exist in these communities, a nurse sometimes walks ten miles a day on her rounds, and some of the walking is up steep hills. On her way, she stops to speak persuasively to those who have not attended the clinic. And, of course, she and the team giving tuberculin tests are consulted about various ailments as they go along.

Sometimes the men are away at work, out at the fishing grounds, so the *Christmas Seal* heads for the open Atlantic. When it arrives, the fishermen launch their small boats and come tossing across the waves, heaving to alongside the *Christmas Seal* and climbing to the deck of the rocking ship. Doctors new to the area watch with fear and trembling, ex-

pecting someone to get drowned, but nobody does.

### Red Men, White Plague

The Yukon and North West Territories, which stretch over a million and a half square miles at the top of the map, present the greatest case-finding challenge in Canada. Slightly less than a million of these miles lie north of the tree line, which is the boundary of the Arctic. The population of this area is about 35,000, including 10,000 Eskimos and 7,000 Indians.

As white men invaded the Arctic, they spread tuberculosis among the Eskimos. About 15 years ago, Canadians became alarmed at stories that the Eskimo population was doomed to extinction unless the TB epidemic could be checked.

Medical services to Indians and Eskimos are the responsibility of the government, and the officers of the Indian and Northern Health Services of the Department of National Health and Welfare went at their job with energy and audacity. X-ray equipment goes into Arctic waters every summer as soon as navigation is possible. Some of the Eskimo bands come down to the shore; sometimes X-ray equipment goes overland from the ship by dog sled to the little settlements; sometimes it goes in by plane.

Active cases by the hundreds have been flown out for sanatorium treatment. Once they are in the sanatorium, the Department of Northern Affairs and Resources makes a real effort to use the patient's time well. There is no doubt that life is changing for the Eskimo and that the economy of the centuries is breaking down. Many must find a new way to make a living. A man with passable English, who can read, write, and figure a little, has a fair chance of getting a job at one of the posts or on a construction job of some sort. So teachers begin to work as soon as the patient is well enough to learn.

Among the patients are many small children. Some are babies, who learn to talk while in the sanatorium. At Mountain Sanatorium, in Hamilton, where many of these children are hospitalized, the staff was concerned lest the children learn only English. All felt that the change from the hospital to the igloo was likely to be drastic enough without the added hazard of a child's not knowing what others in the family were saying or being able to talk to them. The staff therefore went to considerable trouble to get two substitute parents for each child, a man and a woman, from among the adult ambulant Eskimo patients. The "mother" and "father" visited each child daily and talked to him in the language of home.

As a result of this vigorous case-finding and treatment program, the TB death rate among the Eskimos has dropped even more swiftly than it has in the white population. Early diagnosis and prompt treatment gets results among the Eskimos, as elsewhere.

### Out in the Golden West

Distances in the prairie provinces are not as confounding as in the Arctic, nor is the climate as dismaying, but there are enough miles to present problems. Saskatchewan, for example, with a population of less than a million, covers more square miles than the states of New York, Vermont, Maine, New Jersey, Connecticut, New Hampshire, Massachusetts, Pennsylvania, Ohio, and Indiana combined.

One might expect that such a scattered population would find it difficult to organize tuberculosis services. Yet this province has been a notable pioneer in health. Thirty years ago Saskatchewan initiated free sanatorium treatment for any resident with tuberculosis, and the Saskatchewan Anti-Tuberculosis League was the first tuberculosis association in the world to undertake a mass X-ray survey of the entire population, starting in 1941. There is something of a Paul Bunyan flavor to some of the true stories about those early years – such as, for example, the determined farmer who came in for a chest X-ray by tractor when rains had made the road impassable for cars.

The Pacific Ocean and the Rocky Mountains provide British Columbia with a scenic grandeur that is the pride and joy of those who live there. It must be admitted, however, that the magnificent terrain can present real challenges to tuberculosis control.

What is to be done, for example, when a chest X-ray survey is needed in a logging camp deep in the mountain region not connected by road with any center of population? Such a survey was conducted by the combined efforts of the Royal Canadian Navy, the British Columbia Department of Health, the British Columbia Tuberculosis Society, and the logging company. The Navy's part was to take the X-ray equipment to one of the fiordlike harbors along the coast, to which the company had built a road from its camp for bringing out logs. The mobile unit was supplied by the B.C. Tuberculosis Society and was staffed by the provincial department of health. The tuberculosis society also organized the operation. The company provided transportation into the bush and facilities for crew and equipment.

As we said earlier, tuberculosis control programs in the areas where most Canadians live have such a strong family resemblance to those in the United States as to make an observer think of twins. But out where people are fewer and farther between, differences crop up. Something new has to be added in the hinterland by those whose goal is eradication of the tenacious tubercle bacillus. Knowing them, we have full confidence that their energy, ingenuity, resourcefulness, and courage will outlast the germ.

Miss Grant is health education consultant for the Canadian Tuberculosis Association, which she joined in 1943 as Christmas Seal Sale director. Miss Grant has taught school in Saskatchewan; been women's editor of a morning paper in Calgary, Alberta; worked in radio and for the Wartime Information Service. She received a B.A. and an M.A. degree from the University of Saskatchewan and an M.P.H. from the University of Michigan.

# TB CASES and DEATHS in 1957

FINAL tuberculosis data for 1957 indicate a total of 86,861 newly reported tuberculosis cases in continental United States, of which 66,437 were classified as active and probably active. Alaska, Hawaii, and Puerto Rico account for an additional 3,263 cases. The active case rate of 39.0 per 100,000 population was 5.3 per cent lower than the case rate of 41.2 in 1956.

Tuberculosis deaths continued to decline in 1957. There were 13,324 deaths in continental United States compared with 14,061 in 1956. The mortality rate in 1957 was 7.8 per 100,000 population compared with 8.4 in 1956, a decrease of 7.1 per cent.

Despite the substantial decline in the over-all death rate, increases were recorded by nine states. However, because these nine states were not among those which recorded increases between 1955 and 1956, it is safe to assume that these occasional increases among the states do not reflect changes in the general downward trend in the tuberculosis death rate.

Alaska and Puerto Rico continued to have higher rates for both cases and deaths than any state. The death rate in Alaska increased about 10 per cent between 1956 and 1957. Hawaii, on the other hand, recorded exceptionally high decreases in both the case and death rates.

The five states with the highest death rates in 1957 were the same as in 1956—Arizona, Kentucky, Arkansas, (District of Columbia), Tennessee, and New Mexico. States with the highest rates are not necessarily those furnishing the bulk of deaths. For instance, three states, New Jersey, New York, and Pennsylvania, accounted for over 20 per cent of all tuberculosis deaths occurring in continental United States in 1957. In Puerto Rico, 741 deaths were recorded; a total surpassed by only four states.

| State or Territory | New Tuberculosis Cases Reported | | | Tuberculosis Deaths | |
|---|---|---|---|---|---|
| | Total Cases | Active and Probably Active | | | |
| | | Number | Rate[1] | Number | Rate[1] |
| Continental U.S. | 86,861 | 66,437 | 39.0 | 13,324 | 7.8 |
| Alabama | 2,099 | 1,547 | 48.9 | 318 | 10.1 |
| Arizona | 848 | 841 | 78.0 | 223 | 20.7 |
| Arkansas | 1,099 | 822 | 46.2 | 253 | 14.2 |
| California | 6,731 | 6,288 | 45.3 | 906 | 6.5 |
| Colorado | 1,059 | 412 | 24.8 | 110 | 6.6 |
| Connecticut | 747 | 502 | 22.1 | 119 | 5.2 |
| Delaware | 147 | 139 | 32.0 | 46 | 10.6 |
| Dist. of Columbia | 758 | 655 | 79.9 | 110 | 13.4 |
| Florida | 2,414 | 1,716 | 40.8 | 264 | 6.3 |
| Georgia | 1,630 | 1,417 | 37.6 | 261 | 6.9 |
| Idaho | 140 | 91 | 14.1 | 20 | 3.1 |
| Illinois | 7,145 | 5,123 | 52.8 | 740 | 7.6 |
| Indiana | 1,728 | 1,419 | 31.5 | 309 | 6.9 |
| Iowa | 392 | 293 | 10.5 | 79 | 2.8 |
| Kansas | 638 | 429 | 20.4 | 77 | 3.7 |
| Kentucky | 1,816 | 1,800 | 59.2 | 441 | 14.5 |
| Louisiana | 1,534 | 1,298 | 42.3 | 302 | 9.8 |
| Maine | 246 | 224 | 23.9 | 48 | 5.1 |
| Maryland | 1,860 | 1,608 | 55.5 | 319 | 11.0 |
| Massachusetts | 1,628 | 1,600 | 33.1 | 416 | 8.6 |
| Michigan | 5,011 | 2,950 | 38.3 | 448 | 5.8 |
| Minnesota | 1,209 | 677 | 20.4 | 108 | 3.3 |
| Mississippi | 872 | 784 | 36.2 | 166 | 7.7 |
| Missouri | 1,630 | 1,561 | 36.8 | 394 | 9.3 |
| Montana | 301 | 244 | 36.4 | 66 | 9.8 |
| Nebraska | 227 | 210 | 14.6 | 74 | 5.1 |
| Nevada | 109 | 90 | 34.4 | 25 | 9.5 |
| New Hampshire | 117 | 98 | 17.1 | 18 | 3.1 |
| New Jersey | 3,543 | 1,806 | 32.2 | 531 | 9.5 |
| New Mexico | 628 | 469 | 57.7 | 100 | 12.3 |
| New York | 8,804 | 8,535 | 52.9 | 1,552 | 9.6 |
| North Carolina | 1,651 | 1,210 | 27.1 | 222 | 5.0 |
| North Dakota | 117 | 116 | 18.0 | 23 | 3.6 |
| Ohio | 5,009 | 3,269 | 35.5 | 634 | 6.9 |
| Oklahoma | 1,084 | 778 | 34.5 | 162 | 7.2 |
| Oregon | 578 | 495 | 28.4 | 67 | 3.8 |
| Pennsylvania | 7,141 | 4,947 | 44.9 | 1,031 | 9.4 |
| Rhode Island | 372 | 271 | 31.6 | 53 | 6.2 |
| South Carolina | 1,028 | 734 | 31.0 | 190 | 8.0 |
| South Dakota | 158 | 153 | 22.1 | 31 | 4.5 |
| Tennessee | 2,827 | 1,681 | 48.8 | 455 | 13.2 |
| Texas | 3,552 | 2,729[2] | 29.7[2] | 793 | 8.6 |
| Utah | 152 | 136 | 16.2 | 21 | 2.5 |
| Vermont | 114 | 89 | 24.1 | 39 | 10.5 |
| Virginia | 2,122 | 1,519 | 39.7 | 331 | 8.6 |
| Washington | 1,537 | 959 | 35.2 | 113 | 4.1 |
| West Virginia | 963 | 755 | 38.5 | 166 | 8.5 |
| Wisconsin | 1,271 | 888 | 23.0 | 138 | 3.6 |
| Wyoming | 75 | 60 | 18.9 | 12 | 3.8 |
| Alaska | 711 | 431 | 204.3 | 46 | 21.8 |
| Hawaii | 459 | 281 | 45.8 | 20 | 3.3 |
| Puerto Rico | 3,120 | 2,551 | 111.8 | 741 | 32.5 |
| United States and Territories | 91,151 | 69,700 | 40.2 | 14,131 | 8.1 |

[1]Per 100,000 population
[2]Partly estimated
Source: National Office of Vital Statistics and Tuberculosis Program, Division of Special Health Services, Public Health Service.

# NTA Board Committees

## . . . their purpose and functions

**International Affairs**

The month of September this year is a particularly appropriate time to examine the responsibilities, duties, and activities of the National Tuberculosis Association Committee on International Affairs. Under its guidance and aegis, approximately 40 representatives of the United States tuberculosis control movement will participate in the XVth International Tuberculosis Conference from September 11 to 19, in Istanbul, Turkey.

This committee came into being in 1948. It was not, however, the first instance of interest and involvement in international matters on the part of the NTA. Since its formation, the NTA has participated in international conferences on TB, and when the International Union Against Tuberculosis was formed in 1920, the NTA was one of its founding members.

The IUAT is presently a federation of 65 national tuberculosis associations, the majority of which are voluntary associations. Stipulations recently inserted into the IUAT constitution assure the voluntary character of new members.

This voluntary characteristic seemed particularly important in the years following World War II, when intergovernmental agencies such as the World Health Organization were being formed. And it was in the postwar years that an NTA Committee on International Affairs was deemed necessary. The primary charge to this committee is that it "shall advise the Board of Directors on all international relationships of the NTA." Further, the committee is charged with "the responsibility for reviewing and analyzing the organization, the administration, the program and budget of the IUAT."

Twice a year the committee considers at its meetings all aspects of IUAT activity. It suggests members for the technical and administrative committees of the IUAT and is constantly reviewing the program with an eye toward improving its efficacy. Under the guidance of the committee, the NTA supplies representation for the Union to various specialized agencies of the United Nations, such as the WHO and the United Nations Children's Fund (UNICEF). This year a resolution, endorsed by the NTA Board of Directors at the Annual Meeting in May, 1959, and which will be passed, it is expected, by the IUAT Executive Committee, in Istanbul, will be presented by the NTA managing director to the Executive Board of the World Health Organization, urging the latter body to give priority to the eradication of tuberculosis.

In all the above, the committee demonstrates its discharge of the final paragraph of the formal charge: "It will also be the function of the Committee to inform the membership and the governing bodies of the NTA, ATS, and the NCTW of developments in the international field, in order to make more certain that the role to be played by the voluntary tuberculosis movement in the United States may be based upon a comprehensive understanding of the part it can or should assume in international cooperation for the control of tuberculosis."

The members of this year's committee are: Councillors, Mario M. Fischer, M.D. (chairman), H. McLeod Riggins, M.D., Roger S. Mitchell, M.D., Alfred E. Kessler, James E. Perkins, M.D. Alternates, A. W. Dent, LL.D., Herbert C. De Young, William B. Tucker, M.D., Scott Venable, James G. Stone. Committee Members at Large, Edward T. Blomquist, M.D., Esmond R. Long, M.D., Miss Jean South, R.N., and F. D. Hopkins.

**A bronze statue of Florence Rena Sabin, M.D., presented on February 26, was Colorado's first contribution to Statuary Hall, in the U.S. Capitol, where each state is allowed to honor two citizens. Dr. Sabin, who was noted for her research in tuberculosis, the lymphatic system, and the human cell, is the sixth physician to be so honored. She was a teacher of anatomy and professor of histology at The Johns Hopkins Medical School, Baltimore, for 25 years, and a researcher at the Rockefeller Institute for Medical Research, N.Y., for 13 years. In 1945, she was awarded the Trudeau Medal. After her retirement, in Denver, she was active in promoting a series of state public health laws. Below are Arthur Flemming, Secretary of Health, Education and Welfare; Mrs. Joy Buba, sculptor of the Sabin statue; Stephen McNichols, Governor of Colorado; and Senator Gordon Allott, of Colorado.**

# SCIENTISTS AT WORK

Imagine infecting with invisible living organisms a speck so small that it can be seen only under a microscope and watching to see what effect the microorganisms have on the specks.

Tedious and exacting are experiments of this nature, and yet they are necessary if some of the fundamental questions about tuberculosis and other infectious diseases are to be answered.

The intellectual satisfaction of finding answers to such problems keeps Morgan Berthrong, M.D., busy on his "off" afternoons in his basement laboratory at the Glockner-Penrose Hospital, in Colorado Springs, Colo. His studies are aided by grants from the National Tuberculosis Association-American Trudeau Society.*

Dr. Berthrong is trying to determine the role of the cells in resistance to tuberculosis. He is using a technique known as tissue culture in an effort to find out whether tubercle bacilli grow at the same rate in cells from the blood of normal guinea pigs as in those of immune guinea pigs. The technique is known as tissue culture because, as first used, microorganisms were grown on small pieces of animal tissue. As modified and used today by Dr. Berthrong, monocytes are extracted from the peritoneal cavity of guinea pigs and are suspended in test tubes in a special solution.

When the cells are satisfactorily suspended, living virulent tubercle bacilli are planted in the tubes in measured amounts. Dr. Berthrong performs this task under a self-constructed "hood"—a glass box on legs, with holes in the side just large enough for the investigator to put his arms through them. He can thus work with the virulent organisms with a minimum danger of breathing in tubercle bacilli, or of contaminating the cultures from the outside. It is an exacting task, to be done with great care, and all the utensils used in the experiment must be absolutely free of contamination. Dr. Berthrong himself has drawn up the specifications for the 10 steps to be followed in washing and sterilizing the test tubes. Furthermore, time is of the essence, for it is difficult to keep any of the monocytes alive more than 14 or 15 days.

After the bacilli are ingested by the monocytes, there comes a game of watchful waiting. The point is that there are two groups of test tubes, half of them containing cells from normal guinea pigs and the other half cells from guinea pigs made immune to tuberculosis by the inhalation of the vaccine BCG. Will the bacilli grow better in the cells from the normal animals than in those from the immune ones?

Dr. Berthrong has recently reported that cording has been observed within the cells from the normal animals after the sixth day and that eventually the growth of the bacilli has been such that they have literally burst the cells. Cording is a growth characteristic of virulent tubercle bacilli. Since there was no cording when the bacilli were placed in the test tubes and were ingested by the cells, it is obvious that there was intracellular growth. No cording occurred, however, among the cells from the immune animals. Thus, Dr. Berthrong appears to have established that the blood cells play a significant role in immunity to tuberculosis.

The same techniques are also being used to study the effects of cortisone upon cellular resistance, since it is known that cortisone alters the resistance of humans with tuberculosis.

A pathologist, Dr. Berthrong went to Colorado Springs from Johns Hopkins to enable his family of young children to enjoy the wide open spaces of the West. Busy as he is with his duties at the hospital, he manages to spend Wednesday afternoons, as well as intervals during every day, in the basement room which the nuns in charge of the hospital have permitted him to equip as a laboratory. It is there that he has the excitement, as he says, that comes with doing something new. As a pathologist, Dr. Berthrong is interested in the play and interplay of forces in the body that influence susceptibility and resistance to infection. He has found that tuberculosis is the ideal disease for the study of host-parasite relationships, and that the knowledge gained from the study of tuberculosis is applicable to other infectious diseases.

Time was when Colorado Springs was a center of tuberculosis research, but in recent years it has been overshadowed in this respect by Denver. It may be, however, that Colorado Springs is experiencing a rebirth as a research center, for Dr. Berthrong's enthusiasm has proved infectious. His colleagues are now planning research projects in their respective fields.—A.S.F.

*Contributions are being received for this project from the New Jersey Statewide Fund.

Dr. Morgan Berthrong studies the role of cells in resistance to TB.

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## PEOPLE

**Walter Murphy,** who has been public relations account supervisor at Batten, Barton, Durstine & Osborn advertising agency for the past five years, has joined the Education and Public Relations Division of the National Tuberculosis Association as public relations counsel. Prior to his association with BBDO, Mr. Murphy served in a variety of public relations assignments for the Columbia Broadcasting System: director of Press Information for Columbia Records, a division of CBS; manager, Magazine Division, CBS Radio; and director of publicity for station WEEI, the network's station in Boston.

Mr. Murphy's duties as public relations counsel will include working with the staff on the planning and implementation of the NTA's year-round public relations program, and the coordination of continuing activities within the Education and Public Relations Division. In general, he will spearhead an increased public relations effort by the NTA nationally.

**Charles H. Miner, M.D.,** one of the founders of the National Tuberculosis Association, died on July 12. Dr. Miner was also founder of the Wyoming Valley (Pa.) Tuberculosis and Health Society and a past president of the Pennsylvania Tuberculosis and Health Society.

**Vernon Knight, M.D.,** formerly associate professor of medicine, Vanderbilt University School of Medicine, Nashville, Tenn., has been appointed head of clinical research at the National Institute of Allergy and Infectious Diseases. Dr. Knight formerly received a research grant from the National Tuberculosis Association and the American Trudeau Society.

**William B. Tucker, M.D.,** director of the Tuberculosis Service, Veterans Administration, and president-elect of the American Trudeau Society, is visiting the Near East this summer and fall as an American specialist for the International Educational Exchange Service of the Department of State. Dr. Tucker will participate in the XVth International Tuberculosis Conference in Istanbul, and will also confer with doctors and specialists in tuberculosis and chest diseases in a number of Near Eastern countries.

**Sidney A. Slater, M.D.,** who was a member of the Board of Directors of the National Tuberculosis Association from 1930 until his resignation in May this year, died in June. Dr. Slater served as vice president of the NTA in 1947 and was a member of the NTA Executive Committee in 1943 and 1947. He was also a past president of the Minnesota Tuberculosis and Health Association and a member of its Executive Committee at the time of his death.

**Herbert C. De Young,** president-elect of the National Tuberculosis Association, has recently been appointed to the Illinois Commission of Higher Education for a six-year term. Mr. De Young also was awarded the Tuberculosis Institute of Chicago and Cook County Medal for outstanding work in tuberculosis control at the Institute's annual meeting in June.

**Kirby S. Howlett, Jr., M.D.,** medical director of Laurel Heights Sanatorium, Shelton, Conn., and a former president of the American Trudeau Society, was awarded the David Russell Lyman Gold Medal in May. The award has been presented annually since 1952 to a person who has overcome tuberculosis and lived a life of "outstanding productiveness and service in the public welfare." The medal is named for the late medical director of Gaylord Farm Sanatorium, in Wallingford, Conn., who was also at one time president of the National Tuberculosis Association.

**W. Roderick Brown, M.D.,** of the Pittsburgh Tuberculosis Hospital and the Tuberculosis League Hospital, and a member of the Executive Committee of the National Tuberculosis Association, has been appointed director of the Tuberculosis Control Program of the Allegheny County (Pa.) Health Department.

The Queensboro (N.Y.) Tuberculosis and Health Association announces several staff changes: **Miss Marion Melledy** has resigned as director of Detection and Diagnostic Services; she will be replaced by Miss **Theodora Bartkus. H. Garrick Williams** has resigned as director, Special Districts; he has been succeeded by **Robert E. Wallace,** a former assistant in Special Districts, who will have the title of health education director. **Alan Drattell** has resigned as public relations director and is being replaced by **Ridgely Moise, Jr.,** who will act as public relations assistant.

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